1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

CERTIFICATE OF DEATH

03434

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 3 Cherryway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Salisbury
d. STREET ADDRESS: R.D.# 3 Cherryway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle REED — Last BARTLETT

4. DATE OF DEATH: Month March — Day 9 th — Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 19, 1876
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months 3 — Days 20
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroad Conductor-Railroading
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tilghmans Island Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles Bartlett
14. MOTHER'S MAIDEN NAME: (Unk)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Doris Brittingham (Niece) Address R.D.# 3 Cherryway Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident L. with hemi- — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): plegia R. Hypertension essential and hypertensive heart — ?
DUE TO (c): Arteriosclerosis, arteriosclerotic heart disease — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): acute cysto-pyelitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Febo 12, 19 57, to March 9, 19 57, that I last saw the deceased alive on March 8, 19 57, and that death occurred at 9:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 303 East St. (Office) Delmar, Maryland
DATE SIGNED: Mar. 1957

PHYSICIAN'S NAME (Type): Dr. L.V. Sohler M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.11,1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 11 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472 CERTIFICATE OF DEATH

Reg. Dist. No. 03435 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela

c. LENGTH OF STAY IN 1b: 50 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Mardela

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

d. STREET ADDRESS: 1 Rural

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Levin Middle: Thomas Last: Beach

4. DATE OF DEATH: Month: March Day: 30 Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 9, 1872

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Sussex County, Del.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levin Handy Beach

14. MOTHER'S MAIDEN NAME: Amanda Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No ------

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Vernon Beach, Mardela, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4yr

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute cholecystitis & common duct stone

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1, 19 57 to death, 19 ____, that I last saw the deceased alive on 3/28, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M Larmore M.D. ADDRESS (Street, city or town, state): 102 Grove St Delmar Del DATE SIGNED: 4/1/57

PHYSICIAN'S NAME (Type): ERNEST M. LARMORE 102 Grove St. DELMAR, DEL

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-2-1957

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Beach

22d. LOCATION (City, town, or county) (State): Mardela, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles W. Mason Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: APR 3 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03432

CERTIFICATE OF DEATH

03436 337

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 715 Delaware Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alice Middle G. Last Brewington

4. DATE OF DEATH: Month 3 Day 1 Year 1957

5. SEX: F M
6. COLOR OR RACE: A.A.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-4-1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: House Work
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Fred Garfield
14. MOTHER'S MAIDEN NAME: Mary Shelby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Maude Robinson, Address: Route #2, Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 19 57 to Mar 19 57, that I last saw the deceased alive on Mar 19 57, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. A. Purnell M.D. ADDRESS (Street, city or town, state): 612 W Main Salisbury, Md DATE SIGNED: 6 Mar 57

PHYSICIAN'S NAME (Type): E. A. PURNELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-57
22c. NAME OF CEMETERY OR CREMATORY: Green Acres Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md
24a. REC'D BY REGISTRAR DATE: MAR 6 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03437

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH 03433

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 16 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS John B. Parsons Home for Aged

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury

STREET ADDRESS (If rural give location) 1 Lemon Hill

3. NAME OF DECEASED (Type or Print) (First) SENORA (Middle) BELLE (Last) BROWN

4. DATE OF DEATH (Month) MARCH (Day) 26th 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	February 3, 1872	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	None	Snow Hill, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Anthony Brown	Mary E. Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Records: John B. Parsons Home Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X IMMEDIATE CAUSE (A) Cardiovascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19 57, to 3-26, 19 57, that I last saw the deceased alive on 3-26, 19 57, and that death occurred at 4:00A M, from the causes and on the date stated above.

SIGNATURE Philip A Insley M.D. — ADDRESS (Street, city, town, state) E. Main St. Salisbury, Maryland — DATE SIGNED Mar. 28/57

Dr. Philip A. Insley

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 28, 1957	Smullen Cemetery	Worchester Co. Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE APR 1 1957	Mary W Holloway	HOLLOWAY & COMPANY - SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03438

03473

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
c. LENGTH OF STAY IN 1b: app: 15yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1 (Rural)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Quantico
d. STREET ADDRESS: 1 R.D.# 1 (Rural)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ADDIE — Middle — Last COOK

4. DATE OF DEATH: Month MARCH — Day 5 th — Year 19 57

5. SEX: Fe Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 25,1872
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months 7 — Days 10
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Rogersville, Tenn.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: (UNK)
14. MOTHER'S MAIDEN NAME: (UNK)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Byras V. Cook (Son) R.D.# 1(Rural) Quantico, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 5th, 1957, to March 5th, 1957, that I last saw the deceased alive on March 5th, 1957, and that death occurred at 8:45A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William Emrich M.D. — ADDRESS (Street, city or town, state): Main St. (Office) — DATE SIGNED: March. 5th 1957

PHYSICIAN'S NAME (Type): Dr. William Emrich M.D. Hebron, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.8,1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 8 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03439

Items 1,9 FilmG212 3-20-57 et

03434

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 732 Jackson St., Private Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt.Vernon 19x12
d. STREET ADDRESS: Rt.#3 (Princess Ann
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First CLYDE — Middle MARTIN — Last COSTEN

4. DATE OF DEATH: Month 3 — Day 5 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug.22,1887
9. AGE (In years last birthday): 67 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry T. Costen
14. MOTHER'S MAIDEN NAME: Lula Brewington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Joseph Lappin, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: Few Months
DUE TO: 163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-5, 1957, to 3-5, 1957, that I last saw the deceased alive on 3-5, 1957, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur R. Ellis, Jr. M.D. — ADDRESS (Street, city or town, state): Medical Center, Salisbury, Md. — DATE SIGNED: 3/6/57

PHYSICIAN'S NAME (Type): Wilber R.Ellis, Jr. M.D. — Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/57
22c. NAME OF CEMETERY OR CREMATORY: St.Grace Epicopal Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Vernon, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: 3-7-57
24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03474

CERTIFICATE OF DEATH

03440 332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XXX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Willards
d. STREET ADDRESS: XXX
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEVIN Middle T. Last DAVIS

4. DATE OF DEATH: Month March Day 7 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 8, 1870
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Davis
14. MOTHER'S MAIDEN NAME: Mary Godfrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): X (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: X
17. INFORMANT: Mr. Elmer C. Davis Address: Willards, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
331x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-4, 1957, to 3-7, 1957, that I last saw the deceased alive on 3-7, 1957, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Lewis M.D. ADDRESS (Street, city or town, state): Willards Maryland DATE SIGNED

PHYSICIAN'S NAME (Type): FRANK LEWIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/57
22c. NAME OF CEMETERY OR CREMATORY: Dennis
22d. LOCATION (City, town, or county) (State): Willards Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville Del.
24a. REC'D BY REGISTRAR DATE: MAR 12 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film C213 L.L.-57 et

03435

CERTIFICATE OF DEATH

03441

Reg. Dist. No. 33

1

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. — b. COUNTY: Worcester.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop 23X12
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Samuel — Last: Davis

4. DATE OF DEATH: Month: March — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: April 7, 1887

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Bishops, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hiram Burton Davis

14. MOTHER'S MAIDEN NAME: Annie K. Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 221-12-027

17. INFORMANT: Mr. M. P. Davis — Address: Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(b): Coronary Atherosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 3-21, 1957, to 3-24, 1957, that I last saw the deceased alive on 3-24-57, 19, and that death occurred at 10:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore, M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: March 24, 1957

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/27/57 — 22c. NAME OF CEMETERY OR CREMATORY: I O O F Cemetery — 22d. LOCATION (City, town, or county) (State): Bishopville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Irma S. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: MAR 27 1957 — 24b. REGISTRAR'S SIGNATURE: Mary N. Galloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03475 03442

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 404 East Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 05X22 Denton
d. STREET ADDRESS: 5th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Brewster; Last: Deen

4. DATE OF DEATH: Month: March; Day: 12; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney at Law

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Caroline Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Deen

14. MOTHER'S MAIDEN NAME: Caroline Willis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Victoria D. Butler, Delmar, Maryland
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis L. hemiplegia R — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): Cerebral and generalized arteriosclerosis — ?
DUE TO
(c):

332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Skin Cancer L. lower eyelid —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1956, to March 12, 1957, that I last saw the deceased alive on March 12, 1957, and that death occurred at 1:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D.
ADDRESS (Street, city or town, state): 302 East Street Delmar
DATE SIGNED: 3-14-57

PHYSICIAN'S NAME (Type): L. V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 15, 1957
22c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery
22d. LOCATION (City, town, or county) (State): Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.J. Framptom and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR DATE: 3-23-57

24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03476 03443

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Main St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Willards
d. STREET ADDRESS: Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAWRENCE Middle GRANT Last DENNIS

4. DATE OF DEATH: Month March Day 26th Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1903

9. AGE (In years last birthday): 54 yrs. 54

IF UNDER 1 YEAR: Months 2 Days 11
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Willards Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Grant Dennis

14. MOTHER'S MAIDEN NAME: Bettie Burbage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs. Bessie D. Dennis (Wife) Main St. Willards, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullet wound of heart — INTERVAL BETWEEN ONSET AND DEATH: Sudden
976X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound.

20c. TIME OF INJURY: Hour 12:30 o. m. P. M. Month, Day, Year 3-26 19 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Garage at home.

20f. (City or town) Willards (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Mar. 28 1957

EXAMINER'S NAME (Type): Dr. Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 29, 1957
22c. NAME OF CEMETERY OR CREMATORY: DENNIS FAMILY CEMETERY
22d. LOCATION (City, town, or county) (State): Willards, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR (DATE): MAR 29 1957
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03444

03477 **CERTIFICATE OF DEATH**

Reg. Dist. No. 23-r

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Parsonsburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: In Village	d. STREET ADDRESS: 1 In Village — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARTHA	EMILY	DERICKSON	MARCH	20 th	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Sept. 14, 1898	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work at Home	None	Pittsville, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Allison T. Smith	Annie Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
No		Mr. William H. Derickson (Husband)	In Village Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic congestive heart failure	Years
DUE TO	416 X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Rheumatic heart disease	Years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 54, 19____, to 3-2057, 19____, that I last saw the deceased alive on 3-19-57, 19____, and that death occurred at A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royer M.D. — ADDRESS (Street, city or town, state): Camden Ave. (Office) Salisbury, Maryland — DATE SIGNED: March 21 1957

PHYSICIAN'S NAME (Type): Dr. Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar. 22, 1957	Parsonsburg Cemetery	Parsonsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.	MAR 26 1957	Mary H. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03436

CERTIFICATE OF DEATH

03445

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 46 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield 19-39-2
d. STREET ADDRESS: W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ira — Middle: Dorman — Last: Dize

4. DATE OF DEATH: Month: March — Day: 18 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 11 1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Crisfield, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Severn Dize

14. MOTHER'S MAIDEN NAME: Mary Dorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.0
DUE TO (b): Arteriosclerotic heart disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 31, 19 57, to March 18, 19 57, that I last saw the deceased alive on March 18, 19 57, and that death occurred at 10:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andres Grisolia M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland
DATE SIGNED: 3/19/57
PHYSICIAN'S NAME (Type): Andres Grisolia, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/57
22c. NAME OF CEMETERY OR CREMATORY: Crisfield, Cemebery
22d. LOCATION (City, town, or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: for Bozman Funeral Home, Crisfield, Md. — ADDRESS: Jno. L. Carvile
24a. REC'D BY REGISTRAR DATE: 3-26-57
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03478

CERTIFICATE OF DEATH

03446

Reg. Dist. No. 332

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland — c. LENGTH OF STAY IN 1b: 60 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Fruitland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: 1 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EMMA	CATHELL	DULANY	3	24	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Feb. 2, 1865	92 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own Home	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George W. Cathell	Mary Jane Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	--		Mr. Ralph O. Dulany, Fruitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.
DUE TO (b): Coronary Artery Heart Disease — 420.1
DUE TO (c): Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1950, to March 24 1957, that I last saw the deceased alive on March 24, 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gillmore M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 3/25/57

PHYSICIAN'S NAME (Type): David J. Gillmore M.D. Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/27/57	St. John's Cemetery	Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
The Hill & Johnson Co. Salisbury, Maryland	3-25-57	Mary W. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03437 **CERTIFICATE OF DEATH** 03447

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 2yrs 10mo. 14
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): d. Cambridge, Maryland 09-13-2
d. STREET ADDRESS: 819 Roselin Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Dunn

4. DATE OF DEATH: Month: March — Day: 10 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 13, 1869

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Dunn

14. MOTHER'S MAIDEN NAME: Mary Louise Calloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Hospital Records — Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO (b): Arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 24, 1954 to Mar. 10, 1957, that I last saw the deceased alive on Mar. 10, 1957, and that death occurred at 6:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andres Grisolia M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 3/10/57

PHYSICIAN'S NAME (Type): Andres Grisolia, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 12, 1957
22c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem Park
22d. LOCATION (City, town, or county) (State): Cambridge Md

23. FUNERAL DIRECTOR'S SIGNATURE: L. Compton Funeral Service — ADDRESS: Cambridge Md

24a. REC'D BY REGISTRAR DATE: 3/11/57

24b. REGISTRAR'S SIGNATURE: Dorothy Mae Jr. Mary A. Calloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03479 **CERTIFICATE OF DEATH** 03448

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Alice — Last: Evans

4. DATE OF DEATH: Month: Mar. — Day: 2nd — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 1-27-1869

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Whitesville, Del

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harvey Brittingham

14. MOTHER'S MAIDEN NAME: Lovey Foskey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Leslie Evans, Delmar, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c): arteriosclerotic Heart Disease — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchitis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/2, 19 57, to death, 19 ____, that I last saw the deceased alive on Mar 1, 19 57, and that death occurred at 2A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest Larmore M.D. — ADDRESS (Street, city or town, state): Delmar, Del — DATE SIGNED: 3/3/57

PHYSICIAN'S NAME (Type): ERNEST LARMORE — DELMAR, DEL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-5-1957

22c. NAME OF CEMETERY OR CREMATORY: Line

22d. LOCATION (City, town, or county) (State): Whitesville, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mann Co — ADDRESS: Delmar, Del

24a. REC'D BY REGISTRAR. DATE: MAR 5 1957

24b. REGISTRAR'S SIGNATURE: L. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03433

CERTIFICATE OF DEATH

03449

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton 23x02
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Fetkenher

4. DATE OF DEATH: Month: March — Day: 29 — Year: 1957.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 19 1904
9. AGE (In years last birthday) 52 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Douglas Co.
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fetkenher
14. MOTHER'S MAIDEN NAME: Annie Nederhoof

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Buck — Address: Felton, Dela

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis (abdominal) — INTERVAL BETWEEN ONSET AND DEATH:
199.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hepatic insufficiency. Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-7 1957, to 3-29 1957, that I last saw the deceased alive on 3/29/57 19—, and that death occurred at —M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J Gibson M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: March 29 1957
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/1/57
22c. NAME OF CEMETERY OR CREMATORY: East New Market
22d. LOCATION (City, town, or county) (State): East New Market, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth L. Willoughby
ADDRESS: E. N. Market
24a. REC'D BY REGISTRAR DATE: APR 3 1957
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03450

03439 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33r

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Delmar

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

d. STREET ADDRESS: R.D.# 3

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RICHARD Middle LEE Last FOXWELL

4. DATE OF DEATH: Month MARCH Day 15 th Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 17, 1934

9. AGE (In years last birthday): 22 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Employee of Fuller Brush Co, R.D.# 1 Salisbury, Md.

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Richard G. Foxwell

14. MOTHER'S MAIDEN NAME: Evelyn E. Tomlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Elizabeth V. Foxwell (Wife) R.D.# 3 Delmar Md.
Mr. Richard G. Foxwell (Father) Camden Ave. Ext. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic Acidosis & Coma — INTERVAL BETWEEN ONSET AND DEATH: 2 days

260X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 54, to 3-15-57, 19____, that I last saw the deceased alive on 3-15-57, 19____, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lee L Lawry M.D. ADDRESS (Street, city or town, state): Fruitland, Maryland DATE SIGNED: Mar. 17, 1957

PHYSICIAN'S NAME (Type): Dr. Lee Lawry M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 17, 1957

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: MAR 21 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03440

CERTIFICATE OF DEATH

03451

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9x22 HURLOCK
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SARAH — Middle: Ida — Last: Hambrill

4. DATE OF DEATH: Month: MARCH — Day: 17 — Year: 1957

5. SEX: Female — **6. COLOR OR RACE**: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JULY 20, 1862

9. AGE (In years last birthday): 94 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): CAROLINE CO. MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PERRY D. TAYLOR

14. MOTHER'S MAIDEN NAME: ELIZABETH (MAIDEN NAME UNKNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS. CARL L. PUSEY, SALISBURY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute renal failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulm. Surgery for Carcinoma of Breast

DUE TO (c): (Inflamatory Breast Carcinoma & abscess.)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-10, 1957, to 3-17, 1957, that I last saw the deceased alive on 3-17, 1957, and that death occurred at 9:22 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hunter R. Mann Jr. M.D. — ADDRESS (Street, city or town, state): 209 Maryland Ave, Salisbury, Maryland — DATE SIGNED: 3-17-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **22b. DATE THEREOF**: MARCH 19, 1957 — **22c. NAME OF CEMETERY OR CREMATORY**: WASHINGTON CEMETERY — **22d. LOCATION** (City, town, or county) (State): HURLOCK, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.J. FRAMPTOM AND SON, FEDERALSBURG, MD

24a. REC'D BY REGISTRAR DATE: 3-23-57 — **24b. REGISTRAR'S SIGNATURE**: Maryth M. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03452

Reg. Dist. No.

Item 9 FilmG212 3-20-57 at

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): In Village

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Pittsville
d. STREET ADDRESS: / In Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE — Middle VIRGINIA — Last GORDY
4. DATE OF DEATH: Month MARCH — Day 12th — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13,1917
9. AGE (In years last birthday): 58 39 yrs.
IF UNDER 1 YEAR: Months 8 Days 29
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Seaford Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John C. Bozman
14. MOTHER'S MAIDEN NAME: Mary Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Ralph E. Gordy(Husband) Address: Pittsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described abave, held an Autapsy ☒, Inspectian ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 14 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.16,1957
22c. NAME OF CEMETERY OR CREMATORY: Pittsville Cemetery
22d. LOCATION (City, town, or county) (State): Pittsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 15 1957
24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03441

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film C213 4-3-57 et

03453

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westover 19 x 0.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Gordy

4. DATE OF DEATH: Month: 3 — Day: 22 — Year: 19 57

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Gordy

14. MOTHER'S MAIDEN NAME: Lira Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to carbon monoxide poisoning. — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO
(b): Second and third degree burns of face and hands — 35 minutes

DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased was paralyzed and trapped in house when stove exploded

20c. TIME OF INJURY: Hour: 8:05 o. m. Ap. m. — Month, Day, Year: 3-22-57 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Westover (County): Som. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-24-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/24/57
22c. NAME OF CEMETERY OR CREMATORY: St Paul
22d. LOCATION (City, town, or county) (State): Revell Neck, md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William H. James Jr. Princess Anne, md.

24a. REC'D BY REGISTRAR DATE: 3-26-57

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

CERTIFICATE OF DEATH

03454

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 206 Marshall St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAE — Middle DENNIS — Last HANCOCK

4. DATE OF DEATH: Month MARCH — Day 22nd — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept. 21, 1886
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months 6 — Days 1
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee Shirt Factory
10b. KIND OF BUSINESS OR INDUSTRY: (Operator)
11. BIRTHPLACE (State or foreign country): Near Whiton, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Phillip Dennis
14. MOTHER'S MAIDEN NAME: Annie Haddock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Calvin J. Hancock (Son) Address: 904 Spring Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary edema	3 days.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	degenerative heart disease	3 yrs.
DUE TO		
(c)		

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/54, 19___, to 3/22, 19 57, that I last saw the deceased alive on 3/22, 19 57, and that death occurred at 9:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl M Beardsley M.D. ADDRESS (Street, city or town, state): Salisbury, Md DATE SIGNED: 3/22/57

PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley — Maryland Ave. Salisbury, Maryland — March 22, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Bethel Church Cemetery
22d. LOCATION (City, town, or county) (State): Walston, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. RECD BY REGISTRAR DATE: MAR 27 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03455

03443 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 yrs. 10 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown 06x22
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maurice; Middle: McKinney; Last: Hawk

4. DATE OF DEATH: Month: March; Day: 11; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 5, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nelson Hawk

14. MOTHER'S MAIDEN NAME: Mary Catherine Harner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Deer's Head Hospital, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Arteriosclerotic cardiovascular disease — ?
DUE TO
(c):

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 13, 19 53, to March 11, 19 57, that I last saw the deceased alive on March 11, 19 57, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andres Grisolia M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland
DATE SIGNED: 3/11/57

PHYSICIAN'S NAME (Type): Andres Grisolia

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 13, 1957
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Taneytown, Carroll, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss
Merwyn C. Fuss
ADDRESS: Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 13 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Galloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03456

03481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 78 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 704 East Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Delmar
d. STREET ADDRESS: 704 East Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: William — Last: Hearn

4. DATE OF DEATH: Month: Mar. — Day: 9th — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 6, 1878

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Postal Employee, Post Office

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Delmar, Del.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Martin Hearn

14. MOTHER'S MAIDEN NAME: Theodosia LeCates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 221-10-5706

17. INFORMANT: J.Elton Hearn, Delmar, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO
(b): Arteria Sclerosis with Angina attack — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 22, 1956, to Mar 9, 1957, that I last saw the deceased alive on Mar 8, 1957, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. H. Lynch M.D.
ADDRESS (Street, city or town, state): Delmar Del
DATE SIGNED

PHYSICIAN'S NAME (Type): ____

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-12-1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive
22d. LOCATION (City, town, or county) (State): Delmar, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Morrel Co - Delmar, Del
ADDRESS

24a. REC'D BY REGISTRAR DATE: MAR 14 '57
24b. REGISTRAR'S SIGNATURE: Owl. Neil

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03444

CERTIFICATE OF DEATH

03457

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Worcester.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke. 23-42-2
d. STREET ADDRESS: 203 Bonneville Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Eulalia — Middle: — Last: Hickman

4. DATE OF DEATH: Month: March — Day: 11 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan. 22, 1877
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 1
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Accomack
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John William Mullines
14. MOTHER'S MAIDEN NAME: Margaret Ann Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Long Standing
DUE TO
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. p. m. — Month: — Day: — Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-9, 1957, to 3/11, 1957, that I last saw the deceased alive on 3/11, 1957, and that death occurred at 12:15 P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state):
DATE SIGNED:
ACTUAL SIGNATURE: William R. Ellis Jr. M.D.
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/12/57
22c. NAME OF CEMETERY OR CREMATORY: Edgehill
22d. LOCATION (City, town, or county): Accomac (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert D. Littleton
ADDRESS: Accomac, Va
24a. REC'D BY REGISTRAR DATE: MAR 18 1957
24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03445 (03458)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23-42-2
d. STREET ADDRESS: 7 Clarke Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula — Middle: M. — Last: Hitchens

4. DATE OF DEATH: Month: 3 — Day: 13 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 23 1893

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS A. GERMAN

14. MOTHER'S MAIDEN NAME: OLIVIA BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 213-22-4687

17. INFORMANT — Address: FORD D. HITCHENS, JR., POCOMOKE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, cause
420.1
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 9 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-4, 1957, to 3-13, 1957, that I last saw the deceased alive on 3-13, 1957, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis, Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: 3-13-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-15-57
22c. NAME OF CEMETERY OR CREMATORY: GROTON CEMETERY
22d. LOCATION (City, town, or county) (State): HALLWOOD, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Henry A. Watson
ADDRESS: POCOMOKE, MD.
24d. RECD. BY REGISTRAR DATE: MAR 18 1957
24b. REGISTRAR'S SIGNATURE: Mary T. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Wicomico — Maryland — Worcester

Salisbury — 9 days — Pocomoke

Peninsula General Hospital — 7 Clarke Ave.

Lola — Hitchens — 3 — 13 — 57

W — F

Myocardial Infarct, acute — 9 days

3-4 — 57 — 3-13 — 57

3-13 — 57 — 9:15 P

William [illegible] Ellis, Jr. — Salisbury, Md. — 3-13-57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03459

03446 **CERTIFICATE OF DEATH**

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b All his life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury
d. STREET ADDRESS 1 Spring Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Jrome Middle Z Last Holland
4. DATE OF DEATH Month 3 Day 14 Year 1957

5. SEX Male
6. COLOR OR RACE AA
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 5/16/1905
9. AGE (In years last birthday) 51 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Packing Co.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Irvin Holland
14. MOTHER'S MAIDEN NAME Annie Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXXXXXX (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214 12 6812
17. INFORMANT Address Mrs. Susan Hyman, Sp Hill Rd, Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung cancer — INTERVAL BETWEEN ONSET AND DEATH 1 year?
DUE TO 163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Lung abscess
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1957, to March 14, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE L. V. Schler M.D. ADDRESS (Street, city or town, state) 303 East Street, Delmar DATE SIGNED 3-16-57
PHYSICIAN'S NAME (Type) L. V. Schler

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/18/57
22c. NAME OF CEMETERY OR CREMATORY Green Acre Memorial Park
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.
24a. REC'D BY REGISTRAR DATE MAR 20 1957
24b. REGISTRAR'S SIGNATURE Mary L. Galloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03460

03432

CERTIFICATE OF DEATH

Reg. Dist. No. 33-1

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b: 6 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Mardela Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1 (Athol Road)

d. STREET ADDRESS: 1 R.D.# 1 (Athol Road)

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First (ALEX) ALEXANDER — Middle WASHINGTON — Last HOPKINS

4. DATE OF DEATH: Month March — Day 4 th — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 29, 1867

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months 8 Days 5
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware U S A

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshua James Hopkins

14. MOTHER'S MAIDEN NAME: Sarah Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James W. Hopkins (Son) Address: R.D.# 1 (Athol Road) Mardela, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1st, 1957, to March 4th, 1957, that I last saw the deceased alive on March 3rd, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Emrich M.D. ADDRESS (Street, city or town, state): Main St. (Office) DATE SIGNED: March 4th 1957

PHYSICIAN'S NAME (Type): Dr. William Emrich M.D. Hebron, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 6, 1957
22c. NAME OF CEMETERY OR CREMATORY: Emmanuel Church Cemetery
22d. LOCATION (City, town, or county) (State): Mardela, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 7 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03447

CERTIFICATE OF DEATH

03461

Reg. Dist. No. 33

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Carey Ave~~ Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

d. STREET ADDRESS: Carey Ave. R.D.# 3

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GRACE Middle ELLEN Last HUMPHREYS

4. DATE OF DEATH: Month MARCH Day 14th Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 21, 1903

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months 11 Days 23
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work - Shirt Factory Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thomas Hastings

14. MOTHER'S MAIDEN NAME: Mabel Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-10-6482

17. INFORMANT: Mrs. Harry Austin (Daughter) Address: R.D. #3 Carey Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA
199.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): MASSIVE LUNG CANCER
DUE TO (c): DISSEMINATED CERVICAL CANCER,

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/18/56, 19____, to 3/14, 19 57 that I last saw the deceased alive on ____, 19____, and that death occurred at 7:15P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Maryland Ave. (Office) Salisbury, Maryland

DATE SIGNED: Mar. 15 1957

PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitshell
Dr. O.J. Burton

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 17, 1957

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: Mary P. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03443 03462

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar Rt 6 x-3
d. STREET ADDRESS: 200 Grove

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Jackson

4. DATE OF DEATH: Month: 3 — Day: 12 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-11-1902
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Electric Co
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Jackson
14. MOTHER'S MAIDEN NAME: Mary Ellen Kloman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 189-05-6193
17. INFORMANT: Josephine Jackson — Address: Delmar, Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b): Cerebral Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 3, 1957 to March 12, 1957 that I last saw the deceased alive on March 12, 1957, and that death occurred at 4:55 PM, from the causes and an the date stated abave.

ACTUAL SIGNATURE: David J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: March 12, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-15-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Olive
22d. LOCATION (City, town, or county) (State): Delmar Del

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

24a. RECD BY REGISTRAR DATE: MAR 13 1957
24b. REGISTRAR'S SIGNATURE: Mary T. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6212 3-20-57et

03449 03463

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel. R.R.#1.
d. STREET ADDRESS: 46X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Phillip — Middle: I — Last: James

4. DATE OF DEATH: Month: March — Day: 8 — Year: 1957.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 11, 1884

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Reuben James

14. MOTHER'S MAIDEN NAME: Annie Short

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Fannie Short, Seaford, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cirrhosis of liver & Coronary prob. — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-6, 1957, to 3-8, 1957, that I last saw the deceased alive on 3/8, 1957, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Tull Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: 3/10/57 — **22c. NAME OF CEMETERY OR CREMATORY**: Laurel Hill Cem. — **22d. LOCATION** (City, town, or county) (State): Laurel, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: T. E. Dickerson, Laurel, Delaware

24a. REC'D BY REGISTRAR DATE: MAR 11 1957 — **24b. REGISTRAR'S SIGNATURE**: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03464

CERTIFICATE OF DEATH

03450

Reg. Dist. No. 332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 SALISBURY
d. STREET ADDRESS: 1732 JACKSON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: Thomas Last: JAMES IV

4. DATE OF DEATH: Month: MARCH Day: 15 Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 7, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 2 Days: 8
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. James III

14. MOTHER'S MAIDEN NAME: Jancis Costen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Wm. T. James III, Same
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis, acute. — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
Secondary DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Severe dehydration & acidosis — 48 hrs
Secondary DUE TO
(c): Hydrocephalus, Congenital. — 9 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Meningocele with paralysis of lower ext.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 14, 1957 to Mar 15, 1957, that I last saw the deceased alive on Mar 15, 1957, and that death occurred at 10.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R W Saunderson Jr M.D.
ADDRESS (Street, city or town, state): 926 N. Division St Salisbury Md.
DATE SIGNED: 3/15/57

PHYSICIAN'S NAME (Type): R.W. Saunderson, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/57
22c. NAME OF CEMETERY OR CREMATORY: Grace Epic. Chruchyard
22d. LOCATION (City, town, or county) (State): Mt. Vernon, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: 3 1857

24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03451 — Reg. Dist. No. 034657

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillsboro. 05x22
d. STREET ADDRESS: Springhill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mattie Nannie — Middle E. — Last Jarrell
4. DATE OF DEATH: Month 3-4-57 — Day — Year 19

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 20, 1866
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Caroline C. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Hugh Duffey
14. MOTHER'S MAIDEN NAME: Catherine See

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mrs. Joseph M. Eaton, Hillsboro

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio muscular renal disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Arteriosclerosis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953 to March 4, 1957 that I last saw the deceased alive on 3-3, 1957, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Phillip A. Tusley, M.D. — ADDRESS (Street, city or town, state): Salisbury Md. — DATE SIGNED: 3/4/57
PHYSICIAN'S NAME (Type): Phillip A. Tusley — SALISBURY MD

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3/6/57
22c. NAME OF CEMETERY OR CREMATORY: Greenmount.
22d. LOCATION (City, town, or county) (State): Hillsboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Easton Md
24a. REC'D BY REGISTRAR — DATE: MAR 7 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Galloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03452

CERTIFICATE OF DEATH

Reg. Dist. No. 03466 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - POCOMOKE CITY
d. STREET ADDRESS: Box 81 23X22
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle F. — Last Justice

4. DATE OF DEATH: Month March — Day 9 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 14, 1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SERVICE STATION ATTENDENT

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM H. JUSTICE

14. MOTHER'S MAIDEN NAME: SALLIE DIX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): — —

16. SOCIAL SECURITY NO.: 220-26-8450

17. INFORMANT — Address: MRS ANNIE E. JONES, STOCKTON, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: Unknown
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1, 1957, to March 9, 1957, that I last saw the deceased alive on March 9, 1957, and that death occurred at 4:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willis R. Ellis, Jr. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-12-57
22c. NAME OF CEMETERY OR CREMATORY: BRITTINGHAM CEMETERY
22d. LOCATION (City, town, or county) (State): RURAL POCOMOKE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry A. Watson
ADDRESS: POCOMOKE, MD.
24a. RECD BY REGISTRAR — DATE: MAR 13 1957
24b. REGISTRAR'S SIGNATURE: Mary T. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03453

03467

CERTIFICATE OF DEATH

Reg. Dist. No. 33v

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 214 West Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (BABY) First: STARR Middle: LYNN Last: LARMORE

4. DATE OF DEATH: Month: MAR. Day: 18th Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1957

9. AGE (In years last birthday): 0 yrs.
IF UNDER 1 YEAR: Months 0 Days 0
IF UNDER 24 HRS.: Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Raymond Max Larmore

14. MOTHER'S MAIDEN NAME: Beatrice Meredith Budd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Raymond Max Larmore (Father) Address: 214 West Locust St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure i Congenital microcephaly, cyclopia
759.3
DUE TO (b): deformity and absence of nose
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Congenital

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15, 1957, to Mar. 18th, 1957, that I last saw the deceased alive on Mar. 18th, 1957, and that death occurred at 2:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M. Larmore M.D.
ADDRESS (Street, city or town, state): Delmar, Delaware
DATE SIGNED: March 18, 1957

PHYSICIAN'S NAME (Type): Dr.E.M. Larmore

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.19,1957
22c. NAME OF CEMETERY OR CREMATORY: Bivalve Meth Cemetery
22d. LOCATION (City, town, or county) (State): Bivalve, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 21 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Lallerongo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

208232 5 XV5

RECEIVED

MAR 21 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03468

03483 **CERTIFICATE OF DEATH**

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Eden Rt 2
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rural Eden Rt #2
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Helen; Middle May; Last Leatherbury

4. DATE OF DEATH: Month 3; Day 8; Year 1957

5. SEX: F.M.

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/16/1905

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Stephen Jones

14. MOTHER'S MAIDEN NAME: Bertha Tull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ******
(If yes, give war or dates of service): ******

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Leatherbury, Eden, Md. Rt #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 12 Mos.
442X
DUE TO (b): Hypertension — Indefinite
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Feb, 1956, to 8 March, 1957, that I last saw the deceased alive on 8 March, 1957, and that death occurred at 8 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. A. Purnell, M.D. — ADDRESS (Street, city or town, state): 652 W. Main St., Salisbury, Md — DATE SIGNED: 8 March 57

PHYSICIAN'S NAME (Type): E. A. Purnell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/11/1957
22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery
22d. LOCATION (City, town, or county) (State): Polks Road, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: MAR 14 1957

24b. REGISTRAR'S SIGNATURE: Mary K. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03454 Item 9 FilmG212 3-11-57 et

CERTIFICATE OF DEATH

03469 Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 104 W. Vine St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12. Salisbury
d. STREET ADDRESS: 104 W. Vine St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle HANDY — Last LIVINGSTON
4. DATE OF DEATH: Month MARCH — Day 1st — Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov.11, 1871
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Benjamin Peter Livingston
14. MOTHER'S MAIDEN NAME: Martha Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. William M. Livingston (Son) Address: 202 Holland Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): ATHEROSCLEROSIS & HYPERTENSION — Years.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CONGESTIVE CARDIAC FAILURE.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 7, 1953, to 3/1, 1957, that I last saw the deceased alive on 2/28, 1957, and that death occurred at 5:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Maryland Ave.
DATE SIGNED: Mar. 1 1957

PHYSICIAN'S NAME (Type): Dr. O.J. Burton M.D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME— SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 4 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03455

03470

Reg. Dist. No. 331

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place): Since 5/11/56

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pine Bluff State Hospital, Salisbury, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): RFD #2 Spring Hill Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Herbert	Wilson	Lowe, Sr.	March	23	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed	Nov. 7, 1876	80 yrs.	4	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Salisbury, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Samuel Lowe	Ida Isabella Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Patient when admitted to hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Pulmonary Tuberculosis — 1 yr.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 11, 1956, to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 6:40 A.M., from the causes and on the date stated above.

SIGNATURE: [signature] M.D. — ADDRESS (Street, city, town, state): Salisbury, Maryland — DATE SIGNED: 3/23/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 26-57	Wicomico Mem. Park	Salisbury Md.

24. RECD BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MAR 27 1957	Mary H. Holloway	Holloway's Salisbury Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03484 — 03471 — Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela Springs
c. LENGTH OF STAY IN 1b: 3 mos

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Sharptown
d. NAME OF HOSPITAL OR INSTITUTION: Maple Shade Nursing Home
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Edward — Last: Lowe

4. DATE OF DEATH: Month: March — Day: 22 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 29, 1870

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10b. KIND OF BUSINESS OR INDUSTRY: Fish

11. BIRTHPLACE (State or foreign country): Dorchester County, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Lowe

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: L.Fulton Lowe, Sharptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerosis — 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 20, 1957, to Mar 22, 1957, that I last saw the deceased alive on Mar 22, 1957, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.S. Kuhlman M.D. — ADDRESS (Street, city or town, state): Sharptown Md — DATE SIGNED: 3/23/57

PHYSICIAN'S NAME (Type): —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-24-1957

22c. NAME OF CEMETERY OR CREMATORY: East New Market

22d. LOCATION (City, town, or county) (State): East New Market, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Parker W. Hearn — ADDRESS: Sharptown, Md

24a. REC'D BY REGISTRAR DATE: MAR 26 1957

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

Reg. Dist. No. 337

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1. **PLACE OF DEATH** — a. COUNTY: Wicomico — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b: life; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 608 Pearl St.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: Wicomico; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury; d. STREET ADDRESS: 608 Pearl St.; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Irwin; Middle: ; Last: Mitchell

4. **DATE OF DEATH**: Month: 3; Day: 29; Year: 1957

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-4-56

9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months: 7, Days: ; IF UNDER 24 HRS.: Hours: , Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: child

11. BIRTHPLACE (State or foreign country): Wicomico Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irwin Mitchell

14. MOTHER'S MAIDEN NAME: Clara Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Irwin Mitchell — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Sudden

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): ; DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): Earl L. Royer, M.D. — 4-6-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-4-57

22c. NAME OF CEMETERY OR CREMATORY: Berins Cem

22d. LOCATION (City, town, or county) (State): Parsonsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Parker & Church — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 4/10/57

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

2082/84 XVG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03472

03456 **CERTIFICATE OF DEATH**

Reg. Dist. No. 327

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 231 Middle Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLYDE — Middle ORRIS — Last NOCK

4. DATE OF DEATH: Month MARCH — Day 18th — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 15, 1888

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Representative (Employee of Drug Co.)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Accomac County, Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel W. Nock

14. MOTHER'S MAIDEN NAME: Sudie B. Colona

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lelia J. Nock (Wife) Address: 231 Middle Blvd. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420.1
DUE TO
(b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-7, 19 57, to 3-18, 19 57, that I last saw the deceased alive on 3-18, 19 57, and that death occurred at 5:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A. Insley M.D. — ADDRESS (Street, city or town, state): E. Main St. (Office) — DATE SIGNED: Mar. 19 1957

PHYSICIAN'S NAME (Type): Dr. Philip A. Insley M.D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 21, 1957
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: MAR 20 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03473

03457

CERTIFICATE OF DEATH

Reg. Dist. No. 33Y

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Glenmore — Middle: H. — Last: Parker

4. DATE OF DEATH: Month: 3 — Day: 12 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/12/1898

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): Parsonsburg, Md

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John W. Parker

14. MOTHER'S MAIDEN NAME: Annie Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-05-3945

17. INFORMANT: Maxine Fisher — Address: Parsonsburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cong Osteve heart failure — INTERVAL BETWEEN ONSET AND DEATH: Weeks.
DUE TO
(b): Degenerative heart disease — 4 yrs.
DUE TO
(c):

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr, 19 57, to 3/12, 19 57, that I last saw the deceased alive on 3/12, 19 57, and that death occurred at 6:?? M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl M Beardsley M.D. — ADDRESS (Street, city or town, state): Salisbury Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Earl M. Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/17/57

22c. NAME OF CEMETERY OR CREMATORY: Glass Hill

22d. LOCATION (City, town, or county) (State): Parsonsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Custer E. Howard — ADDRESS: Salis. Md

24a. REC'D BY REGISTRAR DATE: MAR 20 1957

24b. REGISTRAR'S SIGNATURE: Mary N. Galloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG213 4-3-57 et

03458

CERTIFICATE OF DEATH

03474

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Mardela
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LOUISE — Middle ELLA — Last PARKINSON

4. DATE OF DEATH: Month MAR. — Day 18th — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 18, 1922

9. AGE (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months 10 — Days 7 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Allen Hooper

14. MOTHER'S MAIDEN NAME: Ruby Truitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Daniel Parkinson (Husband) Address: Mardela, Maryland R.D.# 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Dilatation (Acute Cardiac Dilatation) due to Bronchial Asthma and Status Asthmaticus

241X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Due to Bronchial Asthma & Status Asthmaticus.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Nasal and Sinus Polyposis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19

20d. INJURY OCCURRED While at work ☐ Not While at Work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/3/, 19 53, to 3/18/, 19 57, that I last saw the deceased alive on 3/18/, 19 57, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Medical Center DATE SIGNED: Mar. 19, 1957

PHYSICIAN'S NAME (Type): Dr. Jack J. Waters — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 20, 1957

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: APR 20 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03485 03475

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville Delaware
d. STREET ADDRESS: 46 X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First David — Middle A. — Last Petry

4. DATE OF DEATH: Month March — Day 19 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1876

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: School Teacher

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amos Petry

14. MOTHER'S MAIDEN NAME: Sarah Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): X
(If yes, give war or dates of service): X

16. SOCIAL SECURITY NO.: X

17. INFORMANT: Mrs. Lucele P. Leone — Address: Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency
420.0
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 8, 1956, to March 18, 1957, that I last saw the deceased alive on March 18, 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D.
ADDRESS (Street, city or town, state): Salisbury Md.
DATE SIGNED: March 29, 1957
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/57
22c. NAME OF CEMETERY OR CREMATORY: Red Men
22d. LOCATION (City, town, or county) (State): Selbyville Del.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley
ADDRESS: Selbyville Del.

24a. REC'D BY REGISTRAR (Date): MAR 22 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 213 4-3-57 et

03459

CERTIFICATE OF DEATH

03476

Reg. Dist. No. 332

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia — b. COUNTY: Accomack
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b: 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chincoteague 83X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital	d. STREET ADDRESS: 105 Smith Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First Thomas — Middle JAMES — Last Pitts	4. DATE OF DEATH: Month March — Day 17 — Year 1957
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	8. DATE OF BIRTH: Sept. 1 1873
9. AGE (In years last birthday): 82 yrs.	IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Waterman	10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Green Run Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James R. Pitts	14. MOTHER'S MAIDEN NAME: Mary A. Birch
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT: Henry Pitts — Address: Chincoteague Va	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 16, 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury Md. — DATE SIGNED: May 22, 1957

PHYSICIAN'S NAME (Type): David J. Gilmore — Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: March 20 1957	22c. NAME OF CEMETERY OR CREMATORY: Mackumes	22d. LOCATION (City, town, or county) (State): Chincoteague Va	
23. FUNERAL DIRECTOR'S SIGNATURE: William B. Salyer — ADDRESS		24a. REC'D BY REGISTRAR DATE: 3-22-57	24b. REGISTRAR'S SIGNATURE: Mary W. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03460 03477

Reg. Dist. No. 33r

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mt. Hermon on Schumaker Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 115 E. College Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle GLEN — Last PRICE
4. DATE OF DEATH: Month MARCH — Day 22nd — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 13,1891
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Emory Price
14. MOTHER'S MAIDEN NAME: Laura V. Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Bessie M. Price (Wife) Address: 115 E. College Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO
Died-3:00P.M.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased collapsed in customers home.
20c. TIME OF INJURY: Hour a. m. p. m. 3 P — Month, Day, Year 3- 22 1957
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Salisbury (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 25 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.25,1957
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: MAR 27 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03461

CERTIFICATE OF DEATH

03478
Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Quinton

4. DATE OF DEATH Month: March Day: 16 Year: 1957.

5. SEX: MALE
6. COLOR OR RACE: COLORED
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Wilson Quinton
14. MOTHER'S MAIDEN NAME Lula Mae Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lula Mae Brown
Address: Sharptown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: Hrs Less
DUE TO
(b) Congestive heart failure, right sided, acute — Hrs Less
DUE TO
(c) Unknown etiology

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

773.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Atelectasis, partial, of newborn, passive congestion of liver
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 Mar, 19 57, to 16 Mar, 19 57, that I last saw the deceased alive on 16 Mar, 19 57, and that death occurred at 0945 M, from the causes and on the date stated above.

ACTUAL SIGNATURE R. W. Saunderson Jr. M.D.
ADDRESS (Street, city or town, state) Salisbury Md.
DATE SIGNED 3/17/57

PHYSICIAN'S NAME (Type) R.W. SAUNDERSON, Jr.
Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 3/18/57
22c. NAME OF CEMETERY OR CREMATORY Peninsula General Hospital
22d. LOCATION (City, town, or county) (State) Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Peninsula General Hospital
24a. REC'D BY REGISTRAR DATE 3-18-57
24b. REGISTRAR'S SIGNATURE Mary M. Holloway

2082245XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03486

03479

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Fruitland
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SADIE — Middle SIMMS — Last RUARK

4. DATE OF DEATH: Month 3 — Day 23 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1881

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rufus Simms

14. MOTHER'S MAIDEN NAME: Charlotte Whayland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-03-4704

17. INFORMANT: Mrs. Mary Hearn — Address: Tyaskin, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 4 minutes
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary thrombosis
DUE TO
(c): coronary atherosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 45, to March 23, 19 57, that I last saw the deceased alive on March 21, 19 57, and that death occurred at 3 1 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D. — ADDRESS (Street, city or town, state): 303 East Street, Delmar — DATE SIGNED: 3-23-57

PHYSICIAN'S NAME (Type): L. V. Sohler — Delmar, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/25/1957

22c. NAME OF CEMETERY OR CREMATORY: St. John's Church Cemetery

22d. LOCATION (City, town, or county) (State): Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. — ADDRESS: Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: 3-25-57

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03481

03487

CERTIFICATE OF DEATH

Reg. Dist. No. 334

1. PLACE OF DEATH

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1 Salisbury

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point

STREET ADDRESS (If rural give location) R.D.# 1 Salisbury

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY		SCHIEBEL	MARCH 29th 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 20, 1891	66 yrs.	0	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	None	Augsburg, Germany	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
No Record	Theresa B. Palme

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or detes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Mr. Louis Brewington (Friend) Shad Point R.D.# 1 Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X IMMEDIATE CAUSE (A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 4-6 months

ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Head of Pancreas

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/4, 1956, to 3/28, 1957, that I last saw the deceased alive on 3-28, 1957, and that death occurred at 3:00A M, from the causes and on the date stated above.

SIGNATURE William H Fisher Jr. M.D. — ADDRESS (Street, city, town, state) Medical Center Salisbury, Maryland — DATE SIGNED Mar. 30/57

Dr. William H. Fisher Jr.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 31, 1957	Shad Point Cemetery	R.D.# 1 Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
APR 2 1957	Mary H. Halloway	HOLLOWAY & COMPANY — SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03462 (03482)

CERTIFICATE OF DEATH

Reg. Dist. No. 327

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MARYLAND b. COUNTY: WORCESTER.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY	c. LENGTH OF STAY IN 1b: 20 DAYS — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN 23X02
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL	d. STREET ADDRESS: R.R.#3 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First: John — Middle: P — Last: Short.	4. DATE OF DEATH: Month: MARCH — Day: 15 — Year: 1957
5. SEX: MALE	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 1879	9. AGE (In years last birthday): 78 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY: BUILDING	11. BIRTHPLACE (State or foreign country): BERLIN MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):	16. SOCIAL SECURITY NO.	17. INFORMANT: MRS. KATE SHORT — Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO: Hemorrage & Internal & External
5400
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Gastric Ulcer.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-13, 19 57 to 3-15, 19 57 that I last saw the deceased alive on 3/14/57, 19____, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie L. Heaver M.D. — ADDRESS (Street, city or town, state): 226 N. Division St Salisbury Md — DATE SIGNED

PHYSICIAN'S NAME (Type): Carrie L. Heaver — 226 N. Division St Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	22b. DATE THEREOF: 3/17/57	22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN	22d. LOCATION (City, town, or county) (State): BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE: Anna D Burbage — ADDRESS: Berlin Md	24a. RECD BY REGISTRAR DATE: MAR 18 1957	24b. REGISTRAR'S SIGNATURE: Mary A. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03463

CERTIFICATE OF DEATH

03482 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 6 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 SALISBURY
d. STREET ADDRESS: 1 W. J. ALLEN Co.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Judge — Middle: W. — Last: SKINNER.

4. DATE OF DEATH: Month: MARCH — Day: 16 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: about 7/10/1894

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FRUIT GROWERS

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE L. SKINNER

14. MOTHER'S MAIDEN NAME: ANNA JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-05-9263

17. INFORMANT — Address: P. A. Skinner, 148-25 89 Ave, Jamacia, N. Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
(b): Coronary Insufficiency.
DUE TO
(c): Arteriosclerosis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 15th, 19 57, to March 16, 19 57, that I last saw the deceased alive on March 16, 19 57, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harriet L. Hearn M.D. — ADDRESS (Street, city or town, state): 226 N. Division St Salisbury — DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr Carrie L Hearn — 226 N Division St Salisbury

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/19/1957
22c. NAME OF CEMETERY OR CREMATORY: Green Acre Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. F. Stewart Funeral Home, Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 20 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03484 331

Reg. Dist. No.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin 23x02
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Halistine — Middle: — Last: Smith

4. DATE OF DEATH: Month: 3 — Day: 21 — Year: 19 57

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/2/55

9. AGE (In years last birthday): 1½ yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: child

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Ervin Smith

14. MOTHER'S MAIDEN NAME: Lorretta Purnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Child

17. INFORMANT: Ervin Smith — Address: Berlin Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
881.0
DUE TO (b): Kerosene Poisoning — 3 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Child ingested 2 or more tablespoonsful of Kerosene.

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Child ingested two or more tablespoonsful of kerosene.

20c. TIME OF INJURY Hour: 11:30 o. m. — Month, Day, Year: 3-21-57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Berlin (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 3-24-57

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/25/57

22c. NAME OF CEMETERY OR CREMATORY: Quepunca

22d. LOCATION (City, town, or county): Berlin (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Custard Stewart — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: MAR 27 1957

24b. REGISTRAR'S SIGNATURE: Mary A. Galloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03488

CERTIFICATE OF DEATH

03485

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Allen
d. STREET ADDRESS: 1 In Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN; Middle EDWARD; Last TAYLOR

4. DATE OF DEATH: Month March; Day 3rd; Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1872

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unk

14. MOTHER'S MAIDEN NAME: Jane Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Thomas E. Taylor (Son) 807 E. William St. Salisbury, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Stomach
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1957, to March 3rd, 1957, that I last saw the deceased alive on March 2nd, 1957, and that death occurred at 2:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William Emrich M.D.
ADDRESS (Street, city or town, state): Main St. (Office)
DATE SIGNED: March 4th 1957

PHYSICIAN'S NAME (Type): Dr. William Emrich M.D. Hebron, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 6, 1957
22c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
22d. LOCATION (City, town, or county) (State): Allen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: MAR 7 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MAR 7 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03465 **CERTIFICATE OF DEATH** 03486 Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Spring Hill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: Spring Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Charles — Middle — Last Thomas
4. DATE OF DEATH: Month 3 — Day 21 — Year 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: December
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Henry Thomas
14. MOTHER'S MAIDEN NAME: Lillian Harmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Cathrine A. Thomas — Address: Spring Hill Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Renal Disease
DUE TO
(b): Hypertension
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X
INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 Dec 56 to 21 Mar 1957 that I last saw the deceased alive on 21 Mar 1957, and that death occurred at 1 am M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Purnell, M.D.
ADDRESS (Street, city or town, state): 613 W Main Salisbury, Md
DATE SIGNED: 22 Mar 57
PHYSICIAN'S NAME (Type): E. A. PURNELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 3/24/57
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county): Salisbury (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Anton F. Tennant
ADDRESS: Salis. Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03487

03466

CERTIFICATE OF DEATH

Reg. Dist. No. 337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Salisbury
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital	d. STREET ADDRESS: 1 R.D.# 3 (Mt Hermon) — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: JOHN	Middle: WILSON	Last: TILGHMAN	4. DATE OF DEATH	Month: March	Day: 2nd — Year: 19 57
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 20, 1895	9. AGE (In years last birthday): 61 yrs.	IF UNDER 1 YEAR: Months: 6 Days: 12	IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Mill Operator	10b. KIND OF BUSINESS OR INDUSTRY: Lumberman	11. BIRTHPLACE (State or foreign country): R.D.# 3 Salisbury, Md.	12. CITIZEN OF WHAT COUNTRY?: U S A
13. FATHER'S NAME: Daniel S. Tilghman		14. MOTHER'S MAIDEN NAME: Ida Humphreys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-12-6067	17. INFORMANT: Mrs. Virgie T. Tilghman (Wife) Address: R.D.# 3(Mt Hermon) Salisbury, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 2, 19 57 to March 2, 19 57, that I last saw the deceased alive on March 2, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland — DATE SIGNED: March 5 1957

PHYSICIAN'S NAME (Type): Dr. David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar. 5, 1957	Spring Hill Memorial Gardens	R.D.# Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.	MAR 7 1957	Mary H. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03467 03488

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital	d. STREET ADDRESS: 1 # 41 Belmont Ave e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: DAVID	Middle: GARLAND	Last: TINGLE	4. DATE OF DEATH	Month: MARCH	Day: 12 th	Year: 19 57		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Nov. 30, 1892	9. AGE (In years last birthday): 64 yrs.	IF UNDER 1 YEAR: Months 3	Days 12	IF UNDER 24 HRS.: Hours	Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Restaurant Operator (Restaurant)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): R.D.# Delmar Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: David Tingle		14. MOTHER'S MAIDEN NAME: Martha Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Mr. William F. Tingle (Son) Address: #41 Belmont Ave. Salisbury, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Metastatic Carcinoma	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO (b)	Ca. of Prostate	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from 2-10, 1957, to 3-15, 1957, that I last saw the deceased alive on 3-15, 1957, and that death occurred at 7:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B Smith M.D. ADDRESS (Street, city or town, state): Medical Center DATE SIGNED: Mar. 1957

PHYSICIAN'S NAME (Type): Dr. William B. Smith M.D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Mar. 15, 1957	22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery	22d. LOCATION (City, town, or county) (State): Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		24d. RECD BY REGISTRAR DATE: MAR 18 1957	24b. REGISTRAR'S SIGNATURE: Mary K. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03489

CERTIFICATE OF DEATH

03489

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Nanticoke
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edith Middle: M. Last: Toadvine

4. DATE OF DEATH: Month: March Day: 20 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 14 Aug. 1872

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: 7 Days: 6
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Nanticoke, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ware Walter

14. MOTHER'S MAIDEN NAME: Alice Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elva Toadvine; Address: Nanticoke, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
420.0
DUE TO
(b): Arterio Sclerotic Heart Disease — 5 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 March, 1957 to 20 March, 1957 that I last saw the deceased alive on 20 March, 1957, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D. ADDRESS (Street, city or town, state): Nanticoke Md. DATE SIGNED: 3/21/57

PHYSICIAN'S NAME (Type): Richard H. Saunders Nanticoke, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/23/57
22c. NAME OF CEMETERY OR CREMATORY: Turner's Cemetery
22d. LOCATION (City, town, or county) (State): Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. D. Messick ADDRESS: Bivalve, Maryland

24c. RECD BY REGISTRAR DATE: MAR 25 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03490

CERTIFICATE OF DEATH

03468

Reg. Dist. No. 33

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin

STREET ADDRESS (If rural give location): Ocean City Blvd.

3. NAME OF DECEASED (Type or Print): (First) DOROTHY (Middle) LEE (Last) TOWNSEND

4. DATE OF DEATH: (Month) MARCH (Day) 20 th (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.
Female	White	Widowed	February 6, 1925	32 yrs.	1	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	None	Powellville, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
A. King Powell	Jennie E. West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Mr. J. Russell Townsend (Husband) Ocean City Blvd. Berlin, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X IMMEDIATE CAUSE (A) Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Cx - Stage IV — 18 mos.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work [ ] Not while at work [ ]	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1956, to March 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE Stedman W. Smith — ADDRESS (Street, city, town, state) — DATE SIGNED

Dr. Stedman W. Smith M.D. 706 Camden Ave. Salisbury, Maryland 3/22/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 23, 1957	St. Johns Cemetery	Powellville, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MAR 26 1957	Mary F. Holloway	HOLLOWAY & COMPANY - SALISBURY, MARYLAND

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03469 **CERTIFICATE OF DEATH** 03491

Reg. Dist. No. 33r

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron Rural
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital	d. STREET ADDRESS: R.D.# 1 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: LAURA	Middle: LEE	Last: Twilley	4. DATE OF DEATH Month: March Day: 2 nd Year: 1957

5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Feb. 27, 1957	9. AGE (In years last birthday): 0 yrs.	IF UNDER 1 YEAR Months: 0 Days: 3 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sidney Paul Twilley	14. MOTHER'S MAIDEN NAME: Martha Frances Twilley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service):	16. SOCIAL SECURITY NO.:	17. INFORMANT / Address: Mr. Sidney P. Twilley (Father) R.D.# 1 Hebron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral edema

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Anoxia, acute

DUE TO (c) Chronic Fetal Anoxia

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prematurity c̄ evidence of Placental Insufficiency

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/27 1957 to 3/2 1957 that I last saw the deceased alive on 3/2 1957, and that death occurred at 1035 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgan M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: 3/2/57

PHYSICIAN'S NAME (Type): Dr. William C. Morgan M.D. Salisbury, Maryland Mar. 2, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: Mar. 5, 1957	22c. NAME OF CEMETERY OR CREMATORY: SPRING HILL MEMORIAL GARDENS	22d. LOCATION (City, town, or county) (State): R.D.# Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.	24a. REC'D BY REGISTRAR DATE: MAR 7 1957	24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M C I 82 1 0 2 1

VS A15 (4) 15M 9/55

2d 82333 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03470

CERTIFICATE OF DEATH

03492 337

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1615.2
d. STREET ADDRESS: 4105 Claggett Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amelia — Middle: (NMN) — Last: Wilkinson

4. DATE OF DEATH: Month: March — Day: 20 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/24/1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Reynolds

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records — Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary thrombosis	12 hrs.
DUE TO (b)	Arteriosclerotic cardiovascular disease	?
DUE TO (c)	Arteriosclerosis, generalized	?

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 9, 1952, to Mar. 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death accurred at 7:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 3/20/57

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/22/1957

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Pr.Geo.Co.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.W.Chambers Company, Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 1957

24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

03471

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23422
d. STREET ADDRESS: 819 South St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fred — Middle: T. — Last: Williams

4. DATE OF DEATH: Month: March — Day: 21 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 5 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Williams
14. MOTHER'S MAIDEN NAME: Margaret Mears

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 231-32-8922
17. INFORMANT: Walter Williams — Address: Pocomoke City Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	1 Hr.
DUE TO (b)	Chronic Congestive Heart Failure	2 yrs.
DUE TO (c)	Arteriosclerotic Heart Disease	3-5 yrs.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/20, 1957, to 3/21, 1957, that I last saw the deceased alive on 3/21, 1957, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner Jr. M.D. — ADDRESS (Street, city or town, state): 321 S Div. St. Salisbury, Md. — DATE SIGNED: 3/21/57

PHYSICIAN'S NAME (Type): RUFUS S. GARDNER JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-23-57
22c. NAME OF CEMETERY OR CREMATORY: Downing Cemetery
22d. LOCATION (City, town, or county) (State): Oak Hall, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke Md.
24a. REC'D BY REGISTRAR DATE: 3/27/57
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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